The following is a summary of the new CDC Interim Guidance on Infection Control Measures for 2009 H1N1 Influenza in Healthcare Settings, Including Protection of Healthcare Personnel which was released on October 14, 2009. The complete document is available at http://www.cdc.gov/h1n1flu/guidelines_infection_control.htm

A key point is that **CDC continues to recommend the use respiratory protection that is at least as protective as fit-tested N95 disposable respirators for healthcare personnel who have close contact with patients with suspected or confirmed H1N1 influenza**. In the case of respirator shortages, CDC recommends prioritized use of N95 respirators for higher risk exposures such as aerosol generating procedures.

- The new CDC document describes a hierarchy of controls— measures healthcare facilities should implement to decrease the likelihood of influenza transmission within their facility—such as:
    - Eliminating the source of infections (e.g., exclude ill visitors, keep ill HCWs at home)
    - Engineering controls (e.g., installing partitions in triage areas, perform aerosol-generating procedures in an airborne infection isolation room)
    - Administrative controls (e.g., vaccinating HCWs, respiratory hygiene programs, placing face masks on patients with respiratory symptoms upon entry and during transport)
    - PPE
        - PPE ranks lowest in the hierarchy of controls, and careful implementation of the hierarchy of controls as described above will reduce the need to rely on PPE to prevent infections.
- **Close contact is defined as working within 6 feet of the patient or entering into a small enclosed airspace shared with the patient (e.g., average patient room).**
- Healthcare personnel are defined as all persons whose occupational activities involve contact with patients or contaminated material in a healthcare, home healthcare, clinical laboratory, school-based healthcare setting or correctional facility clinic. Also included are occupations that include patient contact even if they do not involve direct provision of patient care such as dietary and housekeeping services.
- The document recommends promotion and administration of seasonal and H1N1 vaccine to healthcare employees; enforcement of respiratory hygiene and cough etiquette; screen visitors to healthcare setting and limit visitors for patients in isolation; close attention to infection control procedures for patient placement and transport; follow current facility procedures for transport and movement of patient sunder isolation precautions; limit healthcare personnel entering isolation rooms.

- **Shortages of N95 respirators are anticipated and therefore, facilities should maintain a reserve of N95 respirators for persons caring for patients with other infections for which respiratory protection is strongly indicated (e.g., tuberculosis), and persons at very high risk for exposure, such as those performing an aerosol-generating procedure on a patient with suspected or confirmed 2009 H1N1 influenza.** Aerosol-generating procedures are defined as bronchoscopy; sputum induction; endotracheal intubation and extubation; open suctioning of airways; cardiopulmonary resuscitation; autopsies.
- If a shortage is experienced, a system for prioritized respirator use is described for persons NOT performing aerosol-generating activities (please refer to Table 2 in the complete document). In this situation, respirator use may be temporarily discontinued for employees at lower risk of exposure to 2009 H1N1 influenza or lower risk of complicated infection
  - **Facemasks may be used by healthcare personnel for care of suspected a confirmed 2009 H1N1 influenza cases if the facility is in prioritized respirator mode.**
- Isolation precautions for patients who have influenza symptoms should be continued for the 7 days after illness onset or until 24 hours after the resolution of fever and respiratory symptoms, whichever is longer, while a patient is in a healthcare facility.
- Healthcare personnel who develop a fever and respiratory symptoms should be:
  - Excluded from work for at least 24 hours after they no longer have a fever, without the use of fever-reducing medicines.
  - If returning to work in areas where severely immunocompromised patients are provided care, considered for temporary reassignment or exclusion from work for 7 days from symptom onset or until the resolution of symptoms, whichever is longer.
- Healthcare personnel who develop acute respiratory symptoms without fever should be allowed to continue or return to work unless assigned in areas where severely immunocompromised patients are provided care. In this case they should be considered for temporary reassignment or exclusion from work for 7 days from symptom onset or until the resolution of symptoms, whichever is longer.

An OSHA Statement re: H1N1-related inspections was released on Oct 14, 2009 and is available at http://www.osha.gov/pls/oshaweb/owadisp.show_document?p_table=NEWS_RELEASES&p_id=16602. It states that OSHA will issue a compliance directive soon to ensure uniform procedures when conducting inspections.

DOH will revise the Infection Control Guidance posted on its website based on the new CDC recommendations and OSHA's planned enforcement of compliance.